# 2003 BBA Amendment Frequently Asked Questions
# 7/25/2003

| # | SUBJECT | ENTRY DATE | QUESTION (Q.)/ANSWER (A.) |
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| 1 | **Areas of Impact** | 3/31/2003 | **Q.** Can you please share with the plans as soon as possible the areas of the current HO and BH Plus contract that DSHS/MAA believes will be amended to comply with the BBA?<br>**A.** DSHS/MAA is sending out one draft copy of the amended contract. This draft copy will include identification of all the impacted areas. It is the goal of DSHS/MAA to get a draft of the revised contract to CMS and all plans the first week of May. |
| 2 | **Effective Date** | 3/31/2003 | **Q.** If BBA rules are not effective until August 13, 2003, why is the HO contract being amended "the first part of July?<br>**A.** It is the intention of DSHS/MAA that the amendment to the contract be effective July 1, 2003. The amendment will address the implementation date for BBA changes. The effective date for the changes will not be until August 13, 2003. |
| 3 | **Grievance and Appeals effective date** | 06/09/03 | **Q.** What is the effective date of the Grievance and appeals changes?<br>**A.** The Grievance and Appeals changes will be effective the same date as the WAC is effective, or October 1, 2003 whichever date is the later. |
| 4 | **Material effective date** | 06/09/03 | **Q.** When will plans be required to update the plan handbook and other client material to reflect BBA amendment changes?<br>**A.** BBA amendment changes should be reflected in the 2004 – 2005 draft plan handbook that is submitted to DSHS/MAA for review by November 26, 2003. Client letters and other client material should be submitted to DSHS/MAA for review and approval and updated by September 2, 2003. DSHS/MAA will send a notice to clients regarding the changes in the Grievance System. |
| 5 | **Rate setting methodology** | 07/17/03 | **Q.** The new section 3.10, rate setting methodology includes a very brief outline of the methodology. The plans understanding of BBA requirements is that language found in 42 CFR 438.6 appears to require a more detailed overview of the rate setting methodology in the contract and certification by an actuary. "The certification must include a detailed description of the rate setting methodology and document compliance with generally accepted actuarial principles and practices." For an open cooperative contracting procurement, the language in section 45 CFR 74.43 states that the State "signs a contract with any entity meeting the technical programmatic requirements of the State and willing to be reimbursed the actuarially-sound, State-determined rate. Typically a budget percentage factor is applied to a set of rates determined in an actuarially sound manner, including that the budget percentage factor is documented and reasonable." Please provide the plans more detail on how and when DSHS/MAA will be providing the detailed version of the rate setting methodology and the certification by the actuary, which is to be made available to both public and private contractors for review.<br>**A.** CMS requires the contract to have a brief description. The description in the contract is acceptable to CMS. Actuarial certification and documentation for that certification is to CMS and is not in the contract. The rate presentation by Milliman USA on July 14th (occurring after this question was asked) was available to address any additional rate questions. |

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| 6 | **Notice to enrollees** | 07/17/03 | **Q.** New language in section 4.11.2 is very restrictive and may be very difficult to comply with. The timeframe for notice to enrollees affected by provider termination has been shortened from 60 to 15 days. These notices are required to be approved by DSHS/MAA. Drafting a notice, having it approved by DSHS/MAA, and mailing it to enrollees, all within 15 days will be extremely difficult. The plans propose that DSHS/MAA either provide a standard template for notices (eliminating the time necessary to get approval) or that DSHS/MAA extend this timeline to 30 days.<br>**A.** BBA concerning notification of provider termination (42 CFR 438.10(f)(5)):<br>The MCO, PIHP, and, when appropriate, the PAHP or PCCM, must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.<br>DSHS/MAA will change the language to "good faith" instead of "best" and add "or issuing" to address when a plan is initiating a termination. There is no consequence connected with the fifteen days. Letters for notification can be pre-approved formats. The consequence is at 60 days, as it was previously. |
| 7 | **New federal quality standards** | 07/17/03 | **Q.** The new section 5.3 contains very broad language and exposes plans to potentially significant financial risk. We propose this section contain some cost limitation, and/or assurance of cost sharing by DSHS/MAA, and a reasonable timeline for implementation of any new performance measures. - What is DSHS/MAA's expectation of this new requirement for plans to include in our QI programs any national performance measure that may be developed by CMS and adopted by DSHS/MAA? This requirement has potential financial implications that we need to be aware of prior to committing to this Amendment.<br>**A.** DSHS/MAA agrees. The paragraph that was 5.3 and was reformatted to 5.1.3. is deleted. DSHS/MAA will address any new federal quality standards when they become available. |
| 8 | **Advance Directives** | 07/17/03 | **Q.** Section 5.11 - Advance Directives: Please provide the plans with further information on DSHS/MAA's basis for these new requirements which appear to be based off of Medicare + Choice requirements and seem onerous and difficult to comply with given the plans lack of control over agencies, facilities and providers responsibilities around these federal requirements. Please also change the language to match the referenced WAC, which sets an age threshold for the advance directive requirements.<br>**A.** This point is correct in that these are in line with Medicare rules, as is required:<br>BBA Rules state at 42 CFR 438.6:<br>(i) Advance directives. (1) All MCO and PIHP contracts must provide for compliance with the requirements of Sec. 422.128 of this chapter for maintaining written policies and procedures for advance directives.<br>What is essentially required is compliance with requirements that have been in state law for some time. CMS requested the requirements to be more explicitly stated in the contract. If there is an age limitation in state law, it is appropriate for that limitation to be in the plans Policy and Procedures since compliance with state and federal law is what the contract specifically states is required. No change will be made to this section. |

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| 9 | **Data requiring certification** | 07/17/03 | **Q.** Section 6.1 - Please clarify which information and/or data will require certification by a plans CEO, CFO or delegated authority. In the past MAA has verbally communicated that only a select few items require certification. Please verify which items will require certification in the 2003 contract year. - MAA had agreed earlier this year to limit this requirement to only specific reports to limit administrative burden. The plans would like language that supports this agreement.<br>**A.** What needs to be certified is any data that concerns payment – currently encounter data and experience data. DSHS/MAA will look at contract changes for this area for 2004-2005. |
| 10 | **Actions, Grievances and Appeals** | 07/17/03 | **Q.** In Section 6.8, Actions, Grievances and Appeals, a date appears to be incorrect. The data ending September 30 is listed as being due to DSHS/MAA on October 1. The data ending March 31 is not due for 2 months following that date so perhaps the correct date for the September data should be December 1, not October 1.<br>**A.** This error has been corrected in the final version of the amendment. |
| 11 | **Sanctions – Temporary management** | 07/17/03 | **Q.** Section 7.7 Sanctions - please provide the plans with DSHS/MAA's criteria including policies and procedures for implementing or applying appointment of temporary management.<br>**A.** The criteria are stated in the contract. The provision for temporary management is a BBA requirement. After some Q&As with CMS, DSHS/MAA modified the language in the second draft to allow for termination rather than temporary management. DSHS/MAA would very likely terminate the contract rather than impose temporary management. |
| 12 | **Fraud and Abuse Requirements** | 07/17/03 | **Q.** Section 7.27, Fraud and Abuse Requirements – The plans would appreciate DSHS/MAA's consideration of removing the requirement to provide our policies and procedures by March 31st of each year and only require that we provide these documents if there are any substantial changes.<br>**A.** DSHS/MAA will consider the change when doing the 2004-2005 amendment, but DSHS/MAA will require receipt of complete Fraud and Abuse policies and procedures from the plans in 2004 due to the BBA changes. |
| 13 | **Amendment effective term** | 07/17/03 | **Q.** Section 9.1, Term - Please clarify if the Amendment effective term will be from August 13, 2003 through December 31, 2003. Section 9.2.3 - Will there be different termination provisions based on the Amendment renewal for a 4-month period of time? Please clarify as noted in concerns above.<br>**A.** The cover sheet shows the effective date of the amendment as August 13, 2003. The term of the agreement is the same as it was previously. What is effective August 13th are the changes to the contract, which have been affected by replacing the agreement through amendment. The termination provisions will not be changed. |

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| 14 | **Scope of Services** | 07/17/03 | **Q.** Section 10.1, Scope of Services, references the Medicaid State Plan. Health plans do not generally receive a copy of the Medicaid State Plan and therefore cannot assess the operational or financial implications of this clause. The plans suggest this clause be removed or an entire new section be added that clearly states what the "amount, duration and scope described in the Medicaid State Plan" are.<br>**A.** There is no change and no change anticipated in the services that plans must provide and are currently providing. The Medicaid State Plan describes what services are provided to Medicaid clients, both FFS and HO. The services in the contract and FFS have always been limited to state plan services by regulation, but CMS just required an explicit statement in the contract. A copy of the state plan may be obtained through a public disclosure request. |
| 15 | **Enrollee Choice of PCP** | 07/17/03 | **Q.** Section 10.3, Enrollee Choice of PCP, new section states "the contractor shall also allow enrollees with special health care needs as defined in WAC 388-538-050 to retain a specialist as a PCP or be allowed direct access to a specialist if the assessment required under the provisions of this agreement demonstrates a need for a course of treatment or regular monitoring by such specialists (42 CFR 438.208)." The definitions in the referenced WAC only list "Enrollees with Chronic Conditions", not "Enrollees with Special Health Care Needs." It is not appropriate to reference a WAC definition that does not exist. Further, this definition encompasses a very broad class of conditions. Please provide further clarification regarding DSHS/MAA's expectations for the methods used to identify, assess, and case manage enrollees with chronic conditions/ special health care needs as the current language appears to be very broad and has significant financial and operational impact for contractors.<br>**A.** The WAC is in the process of being modified. In review of the draft WAC 388-538 that was sent to the plans. The expectations are stated in sections 10.3 Enrollee Choice of PCP and 10.4 Coordination of Care. |
| 16 | **Special Health Care Needs** | 07/17/03 | **Q.** Section 10.4.3, Identify enrollees with special health care needs and provide case management, assessment and coordination of support services. Please provide further clarification for DSHS/MAA's expectations for this requirement.<br>**A.** DSHS/MAA believes section 10.4, as modified in the second draft of the amendment, along with the QI Standards, states clear expectations around coordination of care. We will consider further clarification as part of the 2004-2005 amendment. |
| 17 | **Age thresholds** | 07/17/03 | **Q.** Section 10.9.2 in the amendment appears to be in conflict with the rules that are referenced in this section. RCW 70.24.110 states an age threshold of 14 and older, RCW 70.96A.095 states an age threshold of 13 and older and RCW 71.34.200 states an age threshold of 18 and older. The language in section 10.9.2 implies that age 18 should be the threshold for all of these services. The plans suggest this language be changed to state the specific age thresholds for each of the services listed. Further, the Healthy Options program is unique among traditional insurance plans in that it does not have a traditional subscriber/member relationship. All "members" are considered unique "subscribers". Please clarify DSHS/MAA's expectations in regard to communicating with "subscribers/members" about these services. For example, when it is legal for a minor to seek services, may the health plan communicate directly with the minor about these services?<br>**A.** This is not new contract language or a new requirement. DSHS/MAA will consider revising this section as part of the 2004-2005 amendment process. |

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| 18 | **Notification to enrollees** | 07/17/03 | **Q.** Section 10.11, information requirements for enrollees and potential enrollees, includes new language requiring plans to notify enrollees of changes to State or Federal law that DSHS/MAA judges to be significant in regard to the enrollees' quality of or access to care. This language is very broad and it is difficult to gauge the financial impact to plans of this clause. The plans suggest that this section be changed to limit the requirement for plans to provide notification to their members to coincide with situations in which DSHS/MAA is also notifying all Fee-For-Service clients in writing of such substantive changes and incurring the cost associated with doing so.<br>**A.** The BBA Rules state:<br><br>42 CFR 438.10(f)(4) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must give each enrollee written notice of any change (that the State defines as ``significant'') in the information specified in paragraphs (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, at least 30 days before the intended effective date of the change.<br><br>The BBA rules are not applicable to the Medicaid FFS program. |
| 19 | **Grievance System** | 07/17/03 | **Q.** Section 10.19, Grievance System, is a very problematic section. This language has apparently been written to match new language that has already been proposed for changes to WAC 388-538. The plans have already communicated a list of major concerns about those proposed WAC changes, as have other health plans and attorneys in the state. As stated previously, these changes have the potential to create onerous financial and administrative burden to health plans, so it is imperative that DSHS/MAA integrates their response to plan concerns and the "final" WAC language with the language in this contract amendment.<br>**A.** DSHS/MAA also believes that some of the new grievance system requirements are problematic. We have address plan concerns in the second draft of the amendment, and will be addressing them in WAC revision, to the extent permitted by CMS. |
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